DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1170 (Rev. 09/01)

STATE OF WISCONSIN

WISCONSIN MEDICAID
WRITTEN CORRESPONDENCE INQUIRY
(OPTIONAL)

INSTRUCTIONS

1. Type or print clearly
2. Complete only the first page of this form. The second page is for use by the Written Correspondence Unit.
3. For more information on submitting written inquiries, contact Provider Services at (800) 947-9627 or (608) 221-9883.

PROVIDER INFORMATION

Provider Name _____

Contact Person _____

Street Address _____

City, State, ZIP Code _____

Wisconsin Medicaid Provider ID Number (eight digits) _____

Provider Area Code and Telephone Number ( ) _____

CLAIM / ADJUSTMENT IN QUESTION

Name — Recipient	Wisconsin Medicaid Recipient ID Number

Claim Number	Date(s) of Service (MM/DD/YYYY)	Amount Billed

Remittance and Status (R/S) Report Date (MM/DD/YYYY)	Explanation of Benefits Code(s)

Other Information

Reason for Inquiry

- ☐ Questioning claim denial that Provider Services could not assist with (please explain below).
- ☐ Provider Services or Professional Relations representative advised writing (please explain below).
- ☐ Inquiry involves extensive documentation or research (please explain below).
- ☐ Other (briefly explain the situation in question below).

SIGNATURE — Provider	Date Signed

The Wisconsin Medicaid Program requires information to enable the Medicaid program to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to the Medicaid program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form.

Retain a copy of this inquiry for your records and send original to:

Wisconsin Medicaid
Written Correspondence Unit
6406 Bridge Road
Madison, WI 53784-0005

Reset Form

Do not complete this page.
This page will be completed by Written Correspondence Unit staff.

REQUEST FOR FURTHER INFORMATION

In order to complete research on your inquiry, Wisconsin Medicaid needs the following information. Please send the information checked below to the Written Correspondence Unit, along with all materials originally sent to the Written Correspondence Unit.

- ☐ Provider name and eight-digit Medicaid provider ID number.
- ☐ Recipient name and 10-digit Medicaid number.
- ☐ Copy of any previous response related to the inquiry.
- ☐ Date of service.
- ☐ Amount billed.
- ☐ R/S Report (copy — not original).
- ☐ Copy of the claim in question.
- ☐ Copy of the Medicare Explanation of Medicare Benefits.
- ☐ Copy of the adjustment in question.
- ☐ Record of treatment dates.
- ☐ Other (briefly explain the situation in question below):

RESOLUTION OF INQUIRY

- ☐ Claim/adjustment was resubmitted by Wisconsin Medicaid through normal processing channels.
- ☐ Claim/adjustment was resubmitted by Wisconsin Medicaid with special instructions for processing.
- ☐ Claim/adjustment has been forwarded for consultant review.
- ☐ Claim was denied correctly. Review _____ and call Provider Services at (800) 947-9627 or (608) 221-9883 if more information is needed.
- ☐ Claim/adjustment was paid on your R/S Report dated _____.
- ☐ Claim/adjustment was denied on your R/S Report dated _____.
- ☐ Claim and documentation was forwarded to Late Billing Appeals for review.
- ☐ Resubmit the claim/adjustment through normal processing channels.
- ☐ This claim exceeds the 12-month filing deadline. Refer to the All-Provider Handbook and resubmit with documentation to Late Billing Appeals ONLY if the claim meets one of the criteria indicated for submission to Late Billing Appeals.
- ☐ Other (briefly explain the situation in question below):

SIGNATURE — Correspondent	Date Signed	Written Control Number

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